Dennis Whalen
Executive Deputy Commissioner
New York State Department of Health
Empire State Plaza
Corning Tower
Albany, New York 12237

Dear Mr. Whalen:

We are pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving New York's request to extend the section 1115 Medicaid demonstration, entitled "The Partnership Plan" (Project No. 11-W-00114/2), for three years effective from April 1, 2003, through March 31, 2006. The approval is under the authority of section 1115(e) of the Social Security Act (SSA). The approved trend rate for the extension is 8.5 percent for all eligibility groups included in the demonstration. This trend rate is effective April 1, 2003, and is reflected in the revised Attachment B to the Special Terms and Conditions (STCs).

With this letter, CMS is also approving the following two amendments to the demonstration. One amendment continues the Community Health Care Conversion Demonstration Project at a level of $250 million in Federal funds for year one and $100 million for year two of the extension period effective April 1, 2003 (revised Attachment J to the STCs.) The second amendment expands family planning services to men and women with net incomes at or below 200 percent of the Federal poverty level effective October 1, 2002, (Attachment N to the STCs). STCs, including revised Attachments B and J and new Attachment N, governing the extension period are enclosed with this letter. Please note that effective October 1, 2002, Attachment N also applies to the original demonstration period and the extended family planning benefit (24 months) to pregnant women who lose Medicaid eligibility after 60 days post-partum.

Our approval of this extension and these amendments to the State of New York's demonstration (and the waivers and Federal matching provided for thereunder) is contingent upon compliance with the enclosed Special Terms and Conditions. These Special Terms and Conditions also set forth in detail the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acceptance of the award within 30 days of the date of this letter.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the New York demonstration. The enclosure with this letter lists the demonstration's approved waivers under section 1115(a)(1) and Federal matching under section 1115(a)(2) of the SSA.

We extend our congratulations on this award and look forward to working with you during the course of the project. Please contact Cheryl Tarver, CMS Central Office, at 410-786-5451 or Michael Melendez, CMS New York Regional Office, at 212-264-9121, if you have any questions on this approval.

Sincerely,

Thomas A. Scully

Enclosure

LIST OF APPROVED WAIVERS UNDER SECTION 1115(a)(1) AND FEDERAL MATCHING UNDER SECTION 1115(a)(2) UNDER THE PARTNERSHIP PLAN

Described below are the waivers approved under section 1115(a)(1) of the Social Security Act and the Federal matching approved under section 1115(a)(2) for The Partnership Plan, as amended on June 29, 2001, with approval of the Family Health Plus (FHPlus) amendment. All waivers and Federal matching are in effect through March 31, 2006.

1. Amount, Duration, and Scope of Services 1902(a)(10)(B)

To the extent that the State may offer a different benefit package to the Safety Net (formerly Home Relief) and/or Family Health Plus (FHPlus) populations from that offered to the traditional Medicaid population.

2. Statewideness 1902(a)(1)

To the extent that the demonstration will be phased-in over a period of time and that some counties in the State will be excluded from participation in The Partnership Plan. In addition, the type and selection of managed care organizations (MCOs) may vary by geographic area. In addition, with respect to FHPlus, in counties with no MCOs, coverage may be provided through commercial insurers approved by the State and CMS.

3. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) 1902(a)(10)

To the extent that the State may provide FQHC and RHC services through MCOs.

4. Freedom of Choice 1902(a)(23)

To the extent the State may restrict freedom-of-choice of provider for Partnership Plan participants on the basis of the efficient and economic provision of covered care and services. With respect to FHPlus, enrollees must select a family planning provider from the MCO's network. If the MCO does not offer such services, the FHPlus enrollee must access family planning services through separate contractual arrangements made by the State.

5. Retroactive Coverage 1902(a)(34)

To recognize that the requirement to retroactively provide medical assistance for 3 months prior to the date the application for such assistance is made does not apply to the Safety Net (formerly Home Relief) or the Family Health Plus populations eligible for The Partnership Plan.

6. Third Party Liability 1902(a)(25)

To the extent that alternative methods for pursuing third party liability will be employed under The Partnership Plan. Specifically, casualty claims will continue to be pursued by the State; non-casualty third party resources will be pursued by managed care organizations. The State will reduce all capitation rates by an actuarially appropriate amount, based on the State's own experience, to reflect the average amount of funds that are expected to be recovered from third parties.

7. Upper Payment Limits for Capitation Contract Requirements 1902(a)(30)

To enable the State to set capitation rates for MCOs in rural areas only that would exceed the actuarial value of Medicaid fee-for-service costs. Any exceptions must be reviewed and approved by CMS.

Under the authority of section 1115(a)(2) of the SSA, expenditures made by the State under The Partnership Plan for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this project, be regarded as expenditures under the State's title XIX plan.

1. Expenditures to provide Medicaid coverage for Safety Net (formerly Home Relief) and FHPlus adults eligible for The Partnership Plan. This population would not otherwise be eligible for Medicaid. Eligibility for coverage through FHPlus is as follows:

Uninsured caretaker parents: as of the FHPlus approval date, those with gross income at or below 120 percent of the Federal poverty level (FPL) and not otherwise eligible for Medicaid coverage; as of October 1, 2001, those with gross income at or below 133 percent of the FPL and not otherwise eligible for Medicaid coverage; and as of October 1, 2002, those with gross income at or below 150 percent of the FPL and not otherwise eligible for Medicaid coverage. In each case eligibility is determined without regard to assets.

Uninsured childless adults with gross income at or below 100 percent of the FPL, without regards to assets.

2. Expenditures for 24 months of extended family planning services provided to Partnership Plan enrollees who lose eligibility 60 days post-partum.

3. Expenditures for family planning services provided to individuals with net incomes at or below 200 percent of the FPL.

4. Expenditures that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

5. Expenditures for capitation payments provided to MCOs which restrict enrollees' right to disenroll within 90 days of enrollment in a new MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4). Disenrollment is permitted as follows:

Partnership Plan:

In New York City before full phase-in of the city: Within 90 days of enrollment into a new MCO.

In New York City after full phase-in of the city, and in other areas of the State: Within 30 days of enrollment into an MCO the enrollee has affirmatively chosen; and within 60 days of enrollment into an MCO into which an enrollee has been assigned by default.

Family Health Plus:

Within 90 days of enrollment into an MCO.

In addition, with respect to Family Health Plus, in counties where two MCOs are not available, enrollees may not disenroll from an MCO, but will be allowed to change primary care providers as specified in the Operational Protocol.

6. Expenditures for prepaid capitation payments to non-health maintenance organizations, as designated under section 1903(m)(2)(A)(i) and 42 CFR 434.20.

7. Expenditures that might otherwise be disallowed under 1903(f); 42 CFR 435.100 et. seq. insofar as they restrict payment to a state for eligibles whose income is no more than 133 1/3 percent of the AFDC eligibility level.

8. Expenditures for providing up to 6 months of guaranteed eligibility from the date of initial eligibility to all Partnership Plan enrollees regardless of which type of managed care organization the beneficiary is enrolled. To enable the State to provide six months of guaranteed eligibility to enrollees from the date of enrollment in a FHPlus plan.

9. Expenditures for services to Partnership Plan managed care enrollees residing in an Institution for Mental Disease for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. This includes individuals eligible for The Partnership Plan who are enrolled in a mainstream MCO for their physical health-only benefits, and are receiving their mental health services either through the fee-for-service wrap-around program or a mental health special needs plan (SNP). This authority applies to FHPlus enrollees, subject to FHPlus coverage limitations.

10. Effective with the date of the award, expenditures for the State programs identified in Attachment J, Section 1 of The Partnership Plan Special Terms and Conditions.

11. Waivers and expenditures for costs not otherwise matchable which are required for implementation of the mandatory behavioral health and HIV/AIDS special needs plans (SNPs) will be awarded once all agreements with regard to the SNP programs are reached with the State, in accordance with the milestone process.